DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**01/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORMSBY HEIGHTS RESIDENTIAL CARE, LLC	**210 SOUTH ORMSBY BLVD, CARSON CITY, NEVADA ,89703**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey and a complaint investigation conducted at your facility on 01/05/23. This State Licensure survey was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The facility is currently licensed for a total of ten Residential Facility for Group beds for elderly and disabled persons, five Category I and five Category II residents. The census at the time of the survey was eight. Eight resident files and six employee files were reviewed. The facility received a grade of A. There was one complaint (CPT) investigated. CPT #NV00067298 with the following allegation could not be substantiated due to lack of evidence. Allegation #1: An employee was working in the facility without a background clearence. The investigation into the allegations included the following: Observation of staff interacting with the residents in the common living area. Interviews with the Administrator and Manager Caregiver. Personnel document review for six employees reviewing State of Nevada background clearence letter. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: KRISTI JOHNSON Title: administrator Date: 02/03/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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0620 SS= D	Written Policy on Admissions - NAC 449.2702 Written policy on admissions; eligibility for residency. (NRS 449.0302) 4. Except as otherwise provided in NAC 449.275 and 449.2754, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; or (d) Requires skilled nursing or other medical supervision on a 24-hour basis. Inspector Comments: Based on observation, clinical record review, and interview, the facility failed to ensure 1) a bedfast resident was not retained or admitted to the facility for 1 of 8 residents (Resident #3) and 2) failed to discharge a resident receiving skilled nursing for wound care for 1 of 8 residents (Resident #3). Findings include: Resident #3 Resident #3 was admitted to the facility on 06/01/20, with a diagnosis of acute diastolic heart failure. Resident #3's clinical record lacked documented evidence of an approved exemption request for wound care and a bedfast waiver from the State of Nevada. On 01/05/22 at 9:20 AM, the Administrator and Manager/Caregiver explained Resident #3 was bedbound, meaning the resident could not turn, nor move independently on their own in bed. The resident needed extensive assistance and the caregivers were responsible for repositioning the resident, if needed. The Administrator and Manager/Caregiver verbalized Resident #3 was receiving wound care by a hospice agency nurse. Severity: 2 Scope: 1	0620	1) A waiver has been attained. 2) In the future, a waiver will be attained for bedfast residents upon admission. 3) Manager and administrator will monitor all new residents to determine if waiver is needed upon admission. 4) Manager and administrator. 5) The waiver for this particular instance has already been attained since inspection. Date attained 1/23/2023.	01/23/2023

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0936 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on record review, document review, and interview, the facility failed to ensure 1 of 8 residents met the requirements for timely tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #8). Findings include: Resident #8 Resident #8 was admitted to the facility on 09/01/22, with diagnosis including depressive disorder, dementia and benign hypertension. Resident #8's clinical record documented a 1 step TB test administered on 08/17/22 and read as negative on 08/19/22. The resident's record lacked documented evidence of a 2nd step TB test upon admission. On 01/05/23 at 12:56 PM, the Manager/Caregiver confirmed Resident #8 lacked evidence of a 2nd step TB test upon admission. Severity: 2 Scope: 1	0936	1) Family member of resident #8 is taking her to have Quantifuron blood test for TB on 2/4/2023, as he lives out of state and was unable to do so before this date. 2) If resident has no local family, they must have a Quantifuron blood test for TB before admission. 3) Manager and administrator will monitor each new admission to determine if they have local family before admission. 4) Manager and administrator. 5) 2/4/2023	02/04/2023

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1700 SS= E	Annual Assessment of History of Each Resident Inspector Comments: Based on record review and interview, the facility failed to obtain a Standard Physician Assessment and Placement Determination for 3 of 8 residents (Resident #2, #4 and #6). Findings include: Resident #2 Resident #2 was admitted to the facility on 11/05/21, with a diagnoses of sycope, unspecified, stage 3b chronic kidney disease and benign prostatic hyperplasia. Resident #2's record lacked documented evidence a Standard Physician Assessment and Placement Determination had been completed. Resident #4 Resident #4 was admitted to the facility on 03/16/16, with a diagnoses of dementia associated with other underlying disease without behavioral disturbances, neuopathy and swollen feet. Resident #4's record lacked documented evidence a Standard Physician Assessment and Placement Determination had been completed. Resident #6 Resident #6 was admitted to the facility on 06/23/22, with a diagnoses of dementia, depression and diabetes mellitus. Resident #6's record lacked documented evidence a Standard Physician Assessment and Placement Determination had been completed. On 01/05/23 at 12:43 PM, the Manager/Caregiver confirmed a Standard Physician Assessment and Placement Determination had not been completed for Resident #2, #4 and #6 and was responsible to ensure all admission documents were accurately and entirely completed. Severity: 2 Scope: 2	1700	1) Standard Physician Assessment and Placement Determination will be obtained for residents 2,4, and 6 by 2/15/2023. 2) A required second check of admission documents will be completed by manager 2 days after admission to ensure all documents have been received. 3) Adminstrator will oversee that the task has been completed by manager. 4) Manager and administrator. 5) 2/15/2023	02/15/2023